wisconsin Medicaid update and BadgerCare

September 2006 ● No. 2006-76

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Blood Banks
Dentists
Dispensing Physicians
Federally Qualified Health Centers
Inpatient Hospital Providers
Nurse Practitioners
Nursing Homes
Outpatient Hospital Providers
Pharmacies
Physician Assistants
Physician Clinics
Physicians
Podiatrists
Rural Health Clinics
HMOs and Other Managed Care Programs

Fall 2006 Preferred Drug List Review

This *Wisconsin Medicaid and BadgerCare Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List. Effective dates for these changes are outlined in this *Update.*

Preferred Drug List Changes

Wisconsin Medicaid has added new classes to the Preferred Drug List (PDL) and made changes to previously reviewed classes. Changes apply to Wisconsin Medicaid and BadgerCare fee-for-service and Wisconsin SeniorCare. The tables on the following pages contain the preferred drugs in each new and reviewed class. As a reminder, prior authorization (PA) is always required for non-preferred drugs and future refills of new non-preferred drugs.

When prescribing non-preferred drugs, prescribers are reminded to complete, sign, and date the appropriate Prior Authorization/ Preferred Drug List (PA/PDL) form and submit it to a pharmacy provider.

New Classes Available on the Preferred Drug List

Wisconsin Medicaid has reviewed and will add androgenic agents, selective serotonin reuptake inhibitor (SSRI) drugs, and hypoglycemics for adjunct therapy to the PDL effective for dates of service (DOS) on and after October 2, 2006.

Androgenic Agents

The following are preferred androgenic agents:

Androgenic Agents
Androderm
Androgel

Wisconsin Medicaid will begin accepting PA requests for non-preferred drugs in this class beginning September 15, 2006.

Selective Serotonin Reuptake Inhibitor Drugs

The following are preferred SSRI drugs:

Selective Serotonin Reuptake Inhibitors
citalopram
fluoxetine
fluvoxamine
paroxetine
Zoloft

Effective for DOS on and after October 2, 2006, for non-preferred SSRI drugs, providers are required to complete the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request, HCF 11075 (Rev. 06/06). Providers are required to *discontinue* using the STAT-PA Drug Worksheet for SSRI Drugs on October 2, 2006. A copy of the completion instructions and the PA/PDL Exemption Request form may be found on the Wisconsin Medicaid Web site.

Hypoglycemic Drugs for Adjunct Therapy

The following are preferred hypoglycemic drugs for adjunct therapy:

Hypoglycemics, Adjunct Therapy
Byetta†
Symlin†
† Preferred agents that require clinical prior authorization.

Both drugs in this class are preferred; however, specific PA criteria are required. To obtain PA, providers are required to complete the PA/PDL for Hypoglycemics for Adjunct Therapy form, HCF 11179 (09/06). Refer to Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update* for the form and completion instructions. A copy of the completion instructions and the PA/PDL for Hypoglycemics for Adjunct Therapy form may be found on the Wisconsin Medicaid Web site.

Specific PA criteria for Byetta include all of the following:

- If the recipient has a diagnosis of Type II diabetes.
- If the recipient has failed to achieve adequate glycemic control despite individualized diabetic medication management.
- If the recipient is receiving ongoing medical care from a health care professional trained in diabetes management.

Specific PA criteria for Symlin include the following:

- If the recipient has a diagnosis of Type I or Type II diabetes.
- If the recipient has failed to achieve adequate glycemic control despite optimal insulin management, including the use of meal time insulin.
- If a recipient is receiving ongoing medical care from a health care professional trained in diabetes management.

If the recipient has any of the following, the PA request for Symlin will be returned:

- An Hemoglobin A1c (HbA1c) greater than 9 percent.
- Recurrent, severe hypoglycemia unawareness.
- A diagnosis of gastroparesis.

Reviewed Classes on the Preferred Drug List

Wisconsin Medicaid has reviewed the following existing PDL drug classes and the preferred drugs are listed below. Changes to the PDL will be effective for DOS on and after October 2, 2006, except as noted. Current, approved PA requests will be honored until their expiration date or until services have been exhausted.

Angiotensin Converting Enzyme (ACE) Inhibitors
benazepril, HCTZ
captopril, HCTZ
enalapril, HCTZ
fosinopril, HCTZ
lisinopril, HCTZ

Alzheimer's Agents
Aricept
Exelon
Namenda

Anticonvulsants
carbamazepine
Carbatrol
Celontin
clonazepam
Depakote, ER, sprinkle
Diastat
Equetro
ethosuximide
Felbatol
gabapentin
Gabitril
Keppra
Lamictal
lamotrigine 25 mg
Lyrica
Mebaral
mephobarbital
Peganone
phenobarbital
phenytoin
primidone
Topamax
Trileptal
valproic acid
zonisamide

Antiemetics, Oral
Emend
Zofran, ODT

Antifungals, Oral
clotrimazole
fluconazole
griseofulvin
Gris-Peg
itraconazole
ketoconazole
nystatin
Mycostatin
Vfend

Antifungals, Topical
ciclopirox cream, suspension
clotrimazole/betamethasone
econazole nitrate
ketoconazole
nystatin
nystatin/triamcinolone

Anti-Parkinson's Agents
benztropine
carbidopa/levodopa
Comtan
Kemadrin
Mirapex
pergolide
Requip
selegiline
Stalevo
trihexyphenidyl

Antivirals, Influenza
amantadine
Relenza
rimantadine
Tamiflu

Antivirals, Other
acyclovir
ganciclovir
Valcyte
Valtrex

Bone Resorption Suppression and Related Agents*
Fosamax, Plus D
Miacalcin
* Changes to this class will be effective for DOS on and after December 1, 2006.

Bronchodilators, Anticholinergic
Atrovent, HFA
Combivent
ipratropium
Spiriva

Bronchodilators, Beta Agonists
albuterol
Maxair
metaproterenol
Proventil HFA
Serevent
terbutaline
Xopenex HFA

Cephalosporins and Related Agents
amoxicillin/clavulanate
amox tr-potassium clavulanate 600
Cedax
cefaclor
cefadroxil
cefpodoxime
cefprozil
cefuroxime
cephalexin
Omnicef
Spectracef
Suprax

Cytokine and Cell Adhesion Molecule Antagonists
Enbrel†
Humira†
Kineret†
Raptiva†
†Preferred agents that require clinical PA.

Fluoroquinolones
Avelox
ciprofloxacin
Levaquin
ofloxacin

Glucocorticoids, Inhaled
Advair, HFA
Aerobid, Aerobid-M
Asmanex
Azmacort
Flovent
Pulmicort Respules
Qvar

Hypoglycemics, Insulin and Related Agents
Humalog
Humalog Mix
Humulin
Lantus
Levemir

Hypoglycemics, Thiazolidinediones
Actos
Avandamet
Avandaryl
Avandia

Intranasal Rhinitis Agents
Astelin
Flonase
flunisolide
ipratropium
Nasacort AQ
Nasonex

Leukotriene Modifiers
Accolate
Singulair

Macrolides/Ketolides
azithromycin
Biaxin XL
clarithromycin
erythromycin
Zmax

Nonsteroidal Anti-inflammatory Drugs
diclofenac, potassium, XL
etodolac, XL
flurbiprofen
ibuprofen
indomethacin, SR
ketoprofen
ketorolac
meclofenamate
meloxicam
nabumetone
naproxen
naproxen sodium, DS
oxaprozin
piroxicam
sulindac

Ophthalmics, Allergic Conjunctivitis
Acular
Alrex
cromolyn
Elestat
ketotifen
Patanol

Ophthalmic Antibiotics
bacitracin/polymyxin
ciprofloxacin solution
erythromycin
gentamicin
ofloxacin
polymyxin/trimethoprim
sulfacetamide
tobramycin
triple antibiotic
Zymar

Ophthalmics, Glaucoma Agents
Alphagan P
Azopt
betaxolol
Betimol
Betopic S
brimonidine
carteolol
Cosopt
dipivefrin
levobunolol
Lumigan
metipranolol
pilocarpine
timolol
Travatan
Trusopt

Platelet Aggregation Inhibitors
Aggrenox
dipyridamole
Plavix
ticlopidine

Stimulants and Related Agents
Adderall XR
amphetamine salt combination
Concerta
dextroamphetamine
Focalin, XR
Metadate CD
methylphenidate ER
Ritalin LA
Strattera*
* Prior authorization is not required for recipients who are 18 and older.

Topical Immunomodulators
Elidel
Protopic

Grandfathered Prescriptions

Effective for DOS on and after October 2, 2006, Wisconsin Medicaid will grandfather prescriptions for recipients who are currently taking non-preferred drugs in the following classes. Recipients currently taking these drugs may remain on the drug indefinitely without PA.

Fall 2006 Grandfathered Drugs	
Drug Class	**Non-preferred Drug**
Alzheimer's agents	Cognex, Razadyne, Razadyne ER
Selective serotonin reuptake inhibitor drugs	Lexapro, Paxil CR, Pexeva, Prozac Weekly, sertraline
Stimulants and related agents	Ritalin LA

Refer to Attachment 5 for a complete list of drug classes that may be grandfathered.

Grandfathering Ends for Xalatan and Istalol

Prescriptions for Xalatan and Istalol will no longer be grandfathered effective for DOS on and after January 1, 2007. These drugs will continue to be non-preferred drugs. Therefore, providers are required to prescribe a preferred drug or submit a PA request to Wisconsin Medicaid for Xalatan or Istalol.

Current, approved PA requests for Xalatan and Istalol will be honored until their expiration date.

Strattera

Prior authorization is not required for Strattera for recipients who are 18 years of age and older; however, PA is required for Strattera for recipients who are younger than 18 years of age. Providers are still required to indicate a

Prescriptions for Xalatan and Istalol will no longer be grandfathered effective for DOS on and after January 1, 2007.

diagnosis code on all claims for Strattera. For diagnosis codes, providers may refer to the Pharmacy page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/*.

When prescribing Strattera, prescribers are required to complete the Prior Authorization/ Preferred Drug List (PA/PDL) for Stimulants and Related Agents, HCF 11097 (06/06). A copy of the completion instructions and the PA/PDL for Stimulants and Related Agents may be found on the Wisconsin Medicaid Web site.

Providers may refer to the September 2005 *Update* (2005-60), titled "Wisconsin Medicaid Enters Multi-State Preferred Drug List and Supplemental Rebate Program," for the PA criteria for Strattera.

Lamisil

Lamisil is an oral antifungal drug that has specific PA approval criteria. To request PA for Lamisil, providers are required to complete the Prior Authorization/Preferred Drug List (PA/PDL) for Lamisil form, HCF 11180 (09/06). Refer to Attachments 3 and 4 for the form and completion instructions and form.

Wisconsin Medicaid may approve a PA request for Lamisil if the recipient has tried and failed, or had an adverse reaction to, a preferred drug, or if the recipient has a diagnosis of onychomycosis or other fungal skin infection (e.g., tinea). If the recipient has a diagnosis of onychomycosis, the recipient must also have a positive potassium hydroxide (KOH) test, culture, or nail biopsy.

If the recipient has a diagnosis of onychomycosis, the recipient must also have one of the following to receive Lamisil:

- Onychomycosis in the fingernail bed.
- A diagnosis of Type I or Type II diabetes.
- Be immunocompromised.
- A severe disability that is a result of the fungal infection.

For all other non-preferred oral antifungal drugs, providers are required to complete only the PA/PDL Exemption Request form.

Brand Medically Necessary Exclusions

When some generic drugs become available, they initially may be more costly for Wisconsin Medicaid than their brand counterparts due to federal and supplemental rebates. For this reason, certain PDL drugs are excluded from the brand medically necessary drug requirements published in the August 2004 *Update* (2004-62), titled "Pharmacy Information on Prior Authorization Requirements for Brand Medically Necessary Drugs." Currently, Flonase, Zocor, and Zoloft are preferred drugs that are excluded from the brand medically necessary policy. Their generics, fluticasone, simvastatin, and sertraline, are non-preferred drugs that require PA.

Wisconsin Medicaid may approve a PA request for Lamisil if the recipient has tried and failed, or had an adverse reaction to, a preferred drug, or if the recipient has a diagnosis of onychomycosis or other fungal skin infection (e.g., tinea).

Effective for DOS on and after September 18, 2006, pharmacy providers may indicate National Council for Prescription Drug Programs Dispense as Written (DAW) code "6" on claims for Flonase, Zocor, and Zoloft. Providers may only submit claims with DAW code "6" for these drugs.

For drugs excluded from brand medically necessary requirements, the following guidelines apply:

- The prescriber is not required to indicate "Brand Medically Necessary" on the prescription.
- The pharmacy provider is not required to obtain PA for the brand name drug.
- The pharmacy provider should dispense the brand name drug.

- SeniorCare participants and Medicaid recipients will pay the generic drug copayment, *not* the brand-name copayment.
- The generic equivalent requires PA. If the pharmacy provider attempts to dispense and submit a claim for the generic equivalent, he or she will receive a message that PA is required.

Note: SeniorCare participants and Medicaid recipients may request an adjustment and refund of brand-name copayments made for Zocor for prescriptions filled on DOS on and after July 1, 2006. To do this, the pharmacy provider should reverse and resubmit the claim(s) for Zocor. The pharmacy provider should reimburse the recipient for the difference between the brand-name and generic copayments; Wisconsin Medicaid will reimburse pharmacy providers this amount.

Pharmacy providers should continue to submit diagnosis codes on claims for preferred diagnosis-restricted drugs.

Reversals and Adjustments

Pharmacy providers may submit online reversals through the Point-of-Sale (POS) system up to 90 days from the DOS. To request adjustments more than 90 days from the DOS, pharmacy providers are required to submit requests on paper using the Adjustment/ Reconsideration Request form, HCF 13046 (Rev. 08/05).

Diagnosis-Restricted Drugs

Drugs that are diagnosis restricted continue to be diagnosis restricted even if they are a preferred drug on the PDL. Pharmacy providers should continue to submit diagnosis codes on claims for preferred diagnosis-restricted drugs. If a drug is both diagnosis restricted and non-preferred, pharmacy providers are required to indicate the appropriate diagnosis code on the PA request if it is submitted through the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or on paper. Refer to the Pharmacy Data Tables on the Pharmacy page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/* for a list of diagnosis codes for preferred diagnosis-restricted drugs.

Tamiflu® Reminder

As a reminder, specific requirements for prescribing Tamiflu® include the following:

- If a recipient is in the first 24 to 36 hours of experiencing signs and symptoms of influenza.
- If a recipient is immunosuppressed or at increased risk of experiencing serious medical complications from, or exposure to, influenza.

Emergency Medication Dispensing Reminder

An emergency medication supply may be dispensed in situations where the pharmacy provider or prescriber deem it is medically necessary.

When drugs are dispensed in an emergency situation, providers are required to submit a Noncompound Drug Claim form, HCF 13072 (Rev. 06/03), with a Pharmacy Special Handling Request form, HCF 13074 (Rev. 06/ 06), indicating the nature of the emergency. Providers should mail completed Noncompound Drug Claim and Pharmacy Special Handling Request forms as indicated on the Pharmacy Special Handling Request form. Medications dispensed in emergency situations do not require PA.

The Pharmacy Special Handling Request form and completion instructions are located in Attachments 6 and 7 for photocopying and may also be downloaded and printed from the Medicaid Web site.

For More Information

Providers should refer to the PDL page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/pdl/index.htm* for the most current PDL. Both preferred and non-preferred drugs are included on the PDL.

The PDL may be revised as changes occur. Changes to the PDL are posted on the Pharmacy page of the Medicaid Web site.

Providers can also refer to the Epocrates Web site at *www.epocrates.com/* to access and download the Wisconsin Medicaid and SeniorCare PDLs to their personal digital assistants (PDAs).

Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 for information about Wisconsin Medicaid, BadgerCare, and SeniorCare coverage of drugs.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants also.

Wisconsin Medicaid, BadgerCare, and SeniorCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Hypoglycemics for Adjunct Therapy Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR HYPOGLYCEMICS FOR ADJUNCT THERAPY COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and dispensing physicians are required to retain a completed copy of the form.

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy, HCF 11179. Pharmacy providers are required to use the PA/PDL for Hypoglycemics for Adjunct Therapy to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

1) For STAT-PA requests, pharmacy providers should call (800) 947-1197 or (608) 221-2096.

2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), HCF 11018, and the appropriate PA/PDL form to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

   Wisconsin Medicaid
   Prior Authorization
   Ste 88
   6406 Bridge Rd
   Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name and Strength
Enter the drug name and strength.

Element 5 — Date Prescription Written
Enter the date the prescription was written.

Element 6 — Directions for Use
Enter the directions for use of the drug.

Element 7 — Name — Prescriber
Enter the name of the prescriber.

Element 8 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

These default codes must *not* be used for prescriptions for controlled substances.

Element 9 — Address and Telephone Number — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code, as well as the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION IIIA — CLINICAL INFORMATION FOR BYETTA
Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 18, check "yes" to all that apply.

Element 10 — Diagnosis — Primary Code and/or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must match the ICD-9-CM description.

Element 11
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Type II diabetes.

Element 12
Check the appropriate box to indicate whether or not the recipient has failed to achieve adequate glycemic control despite individualized diabetic medication management, such as a sulfonyurea or metformin. If "yes" is checked, indicate the recipient's current medication therapy and most current Hemoglobin A1c (HbA1c).

Element 13
Check the appropriate box to indicate whether or not the recipient is receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator.

SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN

Element 14
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Type I or Type II diabetes.

Element 15
Check the appropriate box to indicate whether or not the recipient has failed to achieve adequate glycemic control despite optimal insulin management, including the use of meal time insulin. If "yes" is checked, indicate the recipient's current medication therapy, including insulin regimen.

Element 16
Check the appropriate box to indicate whether or not the recipient has any of the following: an HbA1c greater than 9 percent, recurrent severe hypoglycemia or hypoglycemic unawareness, or a diagnosis of gastroparesis. Indicate the recipient's most current HbA1c value. If the recipient has any of these conditions, the PA will be returned.

Element 17
Check the appropriate box to indicate whether or not the recipient is receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator.

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — Date Signed
Enter the month, day, and year the PA/PDL for Hypoglycemics for Adjunct Therapy was signed (in MM/DD/YYYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply.

Element 22 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 23 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic. For STAT-PA requests, the DOS may be up to 31 days in the future or up to four days in the past.

Element 24 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
00	Not Specified
01	Home
04	Long Term/Extended Care
07	Skilled Care Facility
10	Outpatient

Element 25 — Assigned PA Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 27 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 28 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 29
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.

ATTACHMENT 2
Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Hypoglycemics for Adjunct Therapy" is located on the following pages.)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR HYPOGLYCEMICS FOR ADJUNCT THERAPY

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy Completion Instructions, HCF 11179A.

Pharmacy providers are required to have a completed PA/PDL for Hypoglycemics for Adjunct Therapy signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number	

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name and Strength

5. Date Prescription Written	6. Directions for Use
7. Name — Prescriber	8. Drug Enforcement Agency Number

9. Address and Telephone Number — Prescriber (Street, City, State, Zip Code, and Telephone Number)

SECTION IIIA — CLINICAL INFORMATION FOR BYETTA

10. Diagnosis — Primary Code and / or Description

11. Does the recipient have a diagnosis of Type II diabetes?	❑ Yes	❑ No
12. Has the recipient failed to achieve adequate glycemic control despite individualized diabetic medication management, such as a sulfonyurea, metformin? If yes, indicate the recipient's current medication therapy and most current HbA1c.	❑ Yes	❑ No
13. Is the recipient receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator?	❑ Yes	❑ No

SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN

14. Does the recipient have a diagnosis of Type I or Type II diabetes?	❑ Yes	❑ No
15. Has the recipient failed to achieve adequate glycemic control despite optimal insulin management including the use of meal-time insulin? If yes, indicate the recipient's current medication therapy including insulin regimen.	❑ Yes	❑ No

Continued

SECTION IIIB — INFORMATION FOR SYMLIN (CONTINUED)

16. Does the recipient have any of the following: an HbA1c greater than 9 percent, recurrent severe hypoglycemia or hypoglycemic unawareness, or a diagnosis of gastroparesis? Indicate the most current HbA1c value. ❑ Yes ❑ No

17. Is the recipient receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator? ❑ Yes ❑ No

18. **SIGNATURE** — Prescriber	19. Date Signed

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 digits)	21. Days' Supply Requested (up to 365 days)

22. Wisconsin Medicaid Provider Number (Eight digits)

23. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to four days in the past.)

24. Place of Service (Patient Location) (Use patient location code "00" [Not Specified], "01" [Home], "04" [Long Term / Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient].)

25. Assigned PA Number (Seven digits)

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

29. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid, BadgerCare, or SeniorCare.

ATTACHMENT 3
Prior Authorization/Preferred Drug List (PA/PDL) for Lamisil Completion Instructions

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Lamisil Completion Instructions" is located on the following pages.)

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WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR LAMISIL COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and dispensing physicians are required to retain a completed copy of the form.

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Lamisil, HCF 11180. Pharmacy providers are required to use the PA/PDL for Lamisil to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

1) For STAT-PA requests, pharmacy providers should call (800) 947-1197 or (608) 221-2096.

2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), HCF 11018, and the appropriate PA/PDL form by fax to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

    Wisconsin Medicaid
    Prior Authorization
    Ste 88
    6406 Bridge Rd
    Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name and Strength
Enter the drug name and strength.

Element 5 — Date Prescription Written
Enter the date the prescription was written.

Element 6 — Directions for Use
Enter the directions for use of the drug.

Element 7 — Name — Prescriber
Enter the name of the prescriber.

Element 8 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

These default codes must *not* be used for prescriptions for controlled substances.

Element 9 — Address and Telephone Number — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code, as well as the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION
Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 18, check "yes" to all that apply.

Element 10 — Diagnosis — Primary Code and/or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must match the ICD-9-CM description.

Element 11
Check the appropriate box to indicate whether or not the recipient has tried and failed on or had an adverse reaction to a preferred drug(s). If "yes" is checked, indicate the most recent preferred drug the recipient failed and the approximate dates the drug was taken

Element 12
Check the appropriate box to indicate whether or not the recipient has a diagnosis of onychomycosis.

Element 13
Check the appropriate box to indicate whether or not the recipient had a positive potassium hydroxide (KOH) test, culture, or nail biopsy.

Element 14
Check the appropriate box to indicate whether or not the recipient has another fungal skin infection, such as tinea. If "yes" is checked, indicate the condition.

Element 15
Check the appropriate box to indicate whether or not the onychomycosis is in the fingernail bed.

Element 16
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Type I or Type II diabetes.

Element 17
Check the appropriate box to indicate whether or not the recipient is immunocompromised. If "yes" is checked, indicate the reason.

Element 18
Check the appropriate box to indicate whether or not the recipient has a severe disability as a result of the fungal infection. If "yes" is checked, indicate the disability.

Element 19 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 20 — Date Signed
Enter the month, day, and year the PA/PDL for Lamisil was signed (in MM/DD/YYYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 21 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 22 — Days' Supply Requested
Enter the requested days' supply.

Element 23 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 24 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic. For STAT-PA requests, the DOS may be up to 31 days in the future or up to four days in the past.

Element 25 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
00	Not Specified
01	Home
04	Long Term/Extended Care
07	Skilled Care Facility
10	Outpatient

Element 26 — Assigned PA Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 27 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 28 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 29 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 30
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.

ATTACHMENT 4
Prior Authorization/Preferred Drug List (PA/PDL) for Lamisil

(A copy of the "Prior Authorization/Preferred Drug List [PA/PDL] for Lamisil" is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11180 (09/06)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR LAMISIL

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Lamisil Completion Instructions, HCF 11180A.

Pharmacy providers are required to have a completed PA/PDL for Lamisil signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number	

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name and Strength	
5. Date Prescription Written	6. Directions for Use
7. Name — Prescriber	8. Drug Enforcement Agency Number
9. Address and Telephone Number — Prescriber (Street, City, State, Zip Code, and Telephone Number)	

SECTION III — CLINICAL INFORMATION

10. Diagnosis — Primary Code and / or Description		
11. Has the recipient tried and failed on or had an adverse reaction to a preferred drug(s)? If yes, indicate the most recent preferred drug the recipient failed and the approximate dates the drug was taken.	❑ Yes	❑ No
12. Does the recipient have a diagnosis of onychomycosis?	❑ Yes	❑ No
13. Did the recipient have a positive potassium hydroxide (KOH) test, culture, or nail biopsy?	❑ Yes	❑ No
14. Does the recipient have another fungal skin infection such as tinea? If yes, indicate the condition.	❑ Yes	❑ No
15. Is the onychomycosis in the fingernail bed?	❑ Yes	❑ No
16. Does the recipient have a diagnosis of Type I or Type II diabetes?	❑ Yes	❑ No
17. Is the recipient immunocompromised? If yes, list the reason.	❑ Yes	❑ No
18. Does the recipient have a severe disability as a result of the fungal infection? If yes, indicate the disability.	❑ Yes	❑ No

Continued

SECTION III — CLINICAL INFORMATION (CONTINUED)

19. **SIGNATURE** — Prescriber	20. Date Signed

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

21. National Drug Code (11 digits)	22. Days' Supply Requested (up to 365 days)

23. Wisconsin Medicaid Provider Number (Eight digits)

24. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to four days in the past.)

25. Place of Service (Patient Location) (Use patient location code "00" [Not Specified], "01" [Home], "04" [Long Term / Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient].)

26. Assigned PA Number (Seven digits)

27. Grant Date	28. Expiration Date	29. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

30. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid, BadgerCare, or SeniorCare.

ATTACHMENT 5
Grandfathered Drugs

As of October 2, 2006, Wisconsin Medicaid has grandfathered prescriptions for recipients who are currently taking non-preferred drugs in the following classes. Recipients currently taking non-preferred drugs in these classes may remain on the drug indefinitely without prior authorization (PA).

This list may be revised at any time and providers should refer to the Pharmacy page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/* for the most current list of drugs.

Drug Class
Alzheimer's agents
Anticonvulsants
Antidepressants, other
Anti-Parkinson's agents
Atypical antipsychotics
Selective serotonin reuptake inhibitor drugs
Stimulants and related agents

ATTACHMENT 6
Pharmacy Special Handling Request Completion Instructions

(A copy of the "Pharmacy Special Handling Request Completion Instructions" is located on the following pages.)

WISCONSIN MEDICAID
PHARMACY SPECIAL HANDLING REQUEST
COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and dispensing physicians are required to retain a completed copy of the form.

Pharmacy providers are required to complete and sign the Pharmacy Special Handling Request when appropriate. Pharmacy providers submitting paper claims that require the Pharmacy Special Handling Request may submit the paper claim form with the Pharmacy Special Handling Request to the following address:

Wisconsin Medicaid
Pharmacy Special Handling Unit
Suite 20
6406 Bridge Rd
Madison WI 53784-0020

SECTION I — PROVIDER INFORMATION

Element 1 —Wisconsin Medicaid Provider Identification Number
Enter the provider's eight-digit Wisconsin Medicaid provider identification number.

Element 2 —Telephone Number — Pharmacy Provider
Enter the telephone number, including the area code, of the pharmacy provider.

SECTION II — REASON FOR REQUEST (Choose one.)

Element 3 — Emergency Supply Dispensed
Check the box to indicate that the pharmacy dispensed an emergency supply of up to 14 days per fill.

Element 4 — Original Claim Denied
Check the box to indicate that the original claim was denied and that the pharmacy provider is resubmitting the claim for reconsideration. Include the following information:

- Date of denial.
- Authorization / Internal Control Number.
- Explanation of Benefits (EOB) Number and / or National Council for Prescription Drug Program (NCPDP) Reject Code.
- Description of issue for reconsideration.

Element 5 — National Drug Code (NDC) not on Medicaid file
Check the box to indicate that the NDC submitted on the claim is not on the Medicaid drug file. Include the following information:

- National Drug Code.
- Description of NDC.

Element 6 — Pharmacy Consultant Review
Check the box to indicate that a pharmacy consultant review is being requested. Also check a box to indicate that the pharmacy provider is requesting a review for quantity limits exceeded or "other" reason. Include the following information when requesting an "other" review:

- Explanation of review needed.
- Supporting documentation such as Remittance and Status Report or manufacturer-reviewed and/or peer-reviewed medical literature.

When requesting a review for quantity limits exceeded for triptans, include the following information:

- Complete directions for use. ("As needed" or "PRN" are not sufficient.)
- The maximum triptan dose the prescriber has established by day, week, or month.
- The migraine prophylactic medication the recipient is taking. Specify the drug name, strength, directions for use and compliance.
- Indicate other abortive analgesic headache medications the recipient is taking. Specify the drug name, strength, quantity, directions for use and how frequently the medication is being filled.
- Indicate clinical information from the prescriber regarding the frequency of headaches and either why prophylactic treatment is not being used or why prophylactic treatment has been unsuccessful in reducing the headache frequency.

SECTION III — CERTIFICATION

Element 7 — Signature — Pharmacist or Dispensing Physician
The pharmacy provider or dispensing physician is required to complete and sign this form.

Element 8 — Date Signed
Enter the month, day, and year the Pharmacy Special Handling Request was signed (in MM/DD/YYYY format).

ATTACHMENT 7
Pharmacy Special Handling Request

(A copy of the “Pharmacy Special Handling Request” is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 13074 (Rev. 06/06)

WISCONSIN MEDICAID
PHARMACY SPECIAL HANDLING REQUEST

Instructions: Providers may submit the Pharmacy Special Handling Request and paper drug claim to: Wisconsin Medicaid, Pharmacy Special Handling Unit, Suite 20, 6406 Bridge Road, Madison, WI 53784-0020. Type or print clearly.

SECTION I — PROVIDER INFORMATION

1. Wisconsin Medicaid Provider Number	2. Telephone Number — Pharmacy Provider

SECTION II — REASON FOR REQUEST (Choose one.)

❑ 3. Emergency Supply Dispensed

❑ 4. Original Claim Denied

Date of Denial _____

Authorization / Internal Control Number _____

Explanation of Benefits (EOB) Number and / or National Council for Prescription Drug Program (NCPDP) Reject Code

_____

Description of issue for reconsideration _____

_____

❑ 5. National Drug Code (NDC) Not on Medicaid File

NDC _____

Description _____

❑ 6. Pharmacy Consultant Review

❑ Other: Explanation of review needed. (Provide the explanation in the space below.)

❑ Quantity limits exceeded. (Provide the required documentation in the space below.)

_____

_____

Provide supporting documentation when available (e.g., Remittance and Status Report or manufacturer-reviewed and / or peer-reviewed literature).

_____

_____

_____

_____

SECTION III — CERTIFICATION

7. SIGNATURE — Pharmacist or Dispensing Physician	8. Date Signed